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AUTHOR Reisinger, James John
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ABSTRACT

Described is the Holy Spirit Hospital Early Intervention Program (EIP)--a model for the delivery of services to emotionally disturbed preschoolers via their parents. Various elements (modules) of the program are reported including the intake module, the individual tutoring module, the toddler management module, the intake classroom module, the deficit-remediation classroom module, the community classroom module, and the liason module. A major concern of EIP is noted to be systematic evaluation by an advisory committee of its service delivery program. Provided are tables on EIP's organization, the direct service module structure, and the ancillary module, as well as a sample of a child's progress chart. (SB)

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Educating Parents as Primary Service Providers

James John Reisinger

Bureau of Research and Training (MH)

Eastern Pennsylvania Psychiatric Institute

Elizabeth Hanson Hoffman

Holy Spirit Hospital

Early Intervention Program

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Educating Parents as Primary Service Providers

The Holy Spirit Hospital Early Intervention Program (EIP) is a model for the delivery of services to preschoolers via their own parents. The general design for this model originated with the development of the Regional Intervention Program[1] (RIP) in Nashville, Tennessee. Within a few years, that model was identified as one of a dozen exemplary programs for emotionally disturbed children in the United States. The Holy Spirit Hospital program began in 1973 as a Pennsylvania "replication" of the Tennessee model. The structure of our program followed the basic strategies of measurement and accountability. The measurement of parent and child progress, paralleled with the accountability of staff to trained parent consumers, has shaped the formation of our current training system. In view of time constraints, our presentation today will be primarily descriptive of the EIP model.

The children composing the EIP population range in age from 2 to 5 years; the average being approximately 3.5 years old. They enter the program from a diverse referral base extending from pediatricians to self-initiated inquiries. Diagnostic classifications have included "hyperkinetic reaction" and "unsocialized aggressive reaction of childhood", among others. A child may enter EIP with as many as 5 different labels; none of which suggest treatment direction. EIP thus adopts a focus upon behavior appropriate and necessary in the community. By tracking behavior change throughout EIP training phases, parent and child progress is continuously measured and documented for staff as well as for parents. Since we operate on a federal grant and are not a fee-for-service agency, mothers do not pay for treatment. They do, however, repay 5 hours of time for every 1 hour they receive in training.

Insert Table of Organization Chart

Three Master-level and one Bachelor-level persons comprise the professional resource staff and represent the disciplines of psychology, education, and speech. Aside from a secretary, all other positions are part-time and occupied by trained nonprofessionals, volunteers, and

mothers. A continuing flow of parents first receive services and then assist in delivering similar services under professional supervision. Therefore, the core resource staff functions to provide clearly defined structure in which trained parents help themselves.

Insert Direct Service Modules Chart

The service organization of EIP involves the program's division into distinct elements termed "modules". A module is that element of a system which is intended to operate, with its own resources, to meet a specific need of the child and parents. Thus, a family may proceed through one or all modules as determined by staff assessment and reported family needs. The comprehensive organizational model for our system is abstracted from the approach known as "management by objectives".[2]

The EIP Intake module provides families with an opportunity to discuss program requirements, to observe actual training sessions, and to discuss EIP with parents already receiving services. Simultaneously, this occasion allow staff to observe parent-child interaction and to secure further definition of the primary difficulty. With a decision as to a first priority for a child, entry will usually proceed to either the Individual Tutoring or Toddler Management Module.

The Individual Tutoring Module is intended to produce functional speech in the child by means of training his parents to teach him and also to directly increase his repertoire of adaptive behavior. Depending upon the child, treatment may begin with eye contact, motor imitation, vocal imitation, verbal imitation, naming of objects, or more complex tasks. The child's mother begins by learning to record data on her child's progress. Within a few sessions, mother becomes the teacher. After she has gained confidence in teaching her child, she may begin to teach him at home each day. She may also then teach her husband as she herself was taught by starting him on scoring home sessions. The child is now learning at home while his mother demonstrates progress and confers on procedures in the clinic as determined by her own and her child's needs. Once skilled in these procedures, many parents can not only teach skills like toileting and dressing, but habitually abide by the rule for generalization of learning: any desirable behavior that the child learns anywhere is thereafter re-

quired and reinforced everywhere.

Toddler Management Module deals with children whose behavior is characterized by tantrums and unmanageability. Although some of these children display biological influences, organic impairment is seldom the predominant causal factor of their behavior pattern. In this module's operation, parent and child participate in twenty minute structured play situations. Through the treatment stages of Baseline, Intervention I, Reversal, and Intervention II, the parent-child interaction is analyzed by ongoing data collection. The parent is effectively taught to reinforce cooperative and to ignore uncooperative child behavior. These procedures are so designed to teach parents what to do at home.

As needs dictate, a child who has completed individual treatment sessions may enter the Intake Classroom Module. The teacher then assumes case responsibility for the family and conducts a nursery level instruction program. However, while instruction is the format, emphasis is placed upon appropriate peer interaction. As basic self-control competence is developed, a child is proven eligible for the next classroom level.

The Deficit-Remediation Classroom Module is operated on the assumption, allowing for maturation and variations that these children display parallel play and/or cooperative group behavior. The focus is now definitely educational, with individualized programs and objectives stipulated and measured daily for all children. The program is intended to improve skills in areas such as gross and fine motor control, color and form discrimination, speech, etc.

The final educationally oriented program is maintained in the Community Classroom Module. Children are taught a mastery of basic skills in accord with age, maturation level, and existing preschool standards. This class employs minimal control techniques and is intended as a transitional parallel to interface with many preschool class programs available in the community.

Liaison Module will accept responsbility for the family as the next step may include assistance in placing a child in the community. The Liaison personnel maintain a listing of placements appropriate for various children. They consult with families on available systems and investigate possible placements. In addition to coordinating continued home teaching programs begun by other modules, module personnel actively assist a teacher in programming for the child placed in her nursery

or kindergarten class. They conduct periodic surveys of children no longer primarily served by EIP. Should the family encounter further difficulties, Liaison is the link back to EIP support or intervention systems. Through Liaison, EIP can maintain an open-ended, reciprocal commitment with all families served.

Insert Ancillary Module Chart

There are a number of other service modules including a Nursery and Parent Theory Class, and there will be supportive modules including Public Relations and Technician Training. All of the latter program operations are intended eventually to be completely implemented by trained parents.

Evaluation. EIP has a major concern with the systematic evaluation of its own service delivery program. Yet, with its demonstration mission, categorical funding minimizes any allocation for specific research. However, within such constraints, evaluation methodologies still exist; based usually upon the functional analysis of behavior[3,4,5,6] and designed as an integral part of the service providing mechanism.

For example, the clinical work-record for EIP is composed of behavioral progress notes written daily by parents and professionals, and of data assembled from each training session. The child's graph provides a summary presentation of a completed parent-child training case from Toddler Management. Across sessions and treatment phases, the data indicate declined oppositional or cooperative child behavioral interaction thus serve as the basis for measurement of their progress. Similarly, change and non-change displayed here provide a daily feedback system to inform parent and professional whether their intervention strategies are effective. Thus, measurement and accountability prevail. Decisions and modifications in the EIP system are based upon data in place of clinical judgement.

Insert Figure (Graph)

An important component of EIP is the Advisory Committee. One purpose of the Advisory Committee is to provide recommendations based upon program evaluation data. The composition of the committee includes a minimum of 50% consumer parents, with the remainder being

interested community persons. This group meets at least monthly. It may request any information of program staff, evaluate it, and render a binding opinion regarding the adequacy of program results. Within the context of day-to-day operations, program staff do retain full authority for the manner in which data is collected for the Committee. Thus, program personnel may develop their own methods for accomplishing outcomes, but the entire system is nevertheless accountable for its results to those persons it serves. Consumers, with consultative professional guidance, decide upon the adequacy of services they receive.

Additionally, the EIP Advisory Committee can and does collect its own data independent of program staff. For example, a follow-up questionnaire is used for parents who had completed or terminated the program. The results are received directly by the Advisory Committee. Therefore, we have parents communicating with parents regarding pros and cons of operations and we simultaneoulsy avoid potential biasing effects that could result were line staff conducting this type of assessment. The Advisory Committee then periodically informs professional staff of continuous consumer reactions translating these in the forms of recommended programmatic changes.

Within-program studies are also conducted. These applied research endeavors are conducted upon specific modules and their effects. Such studies do not substantially modify existing operations but rather take microscopic samples of on-going programming and outcomes. They may be implemented by program staff and/or by professionals affiliated with universities, research facilities, and so forth. To date, two such studies have been completed and are under revision for publication.

(1) Reisinger and Ora[7] studied the interaction of parent-child pairs in the clinic and in the home during Toddler Management training. Conclusions were: (a) that in the presence of visible observers, parents were able to generalize training procedures across environments; and (b) with less obtrusive observation (i.e., time delayed tape recordings), parents continued to function as change agents for their children.

(2) Reisinger, Frangia, and Hoffman[8] tracked parent-child pairs in a follow-up study to examine parental skill in technique application one year after clinic training was completed. Two

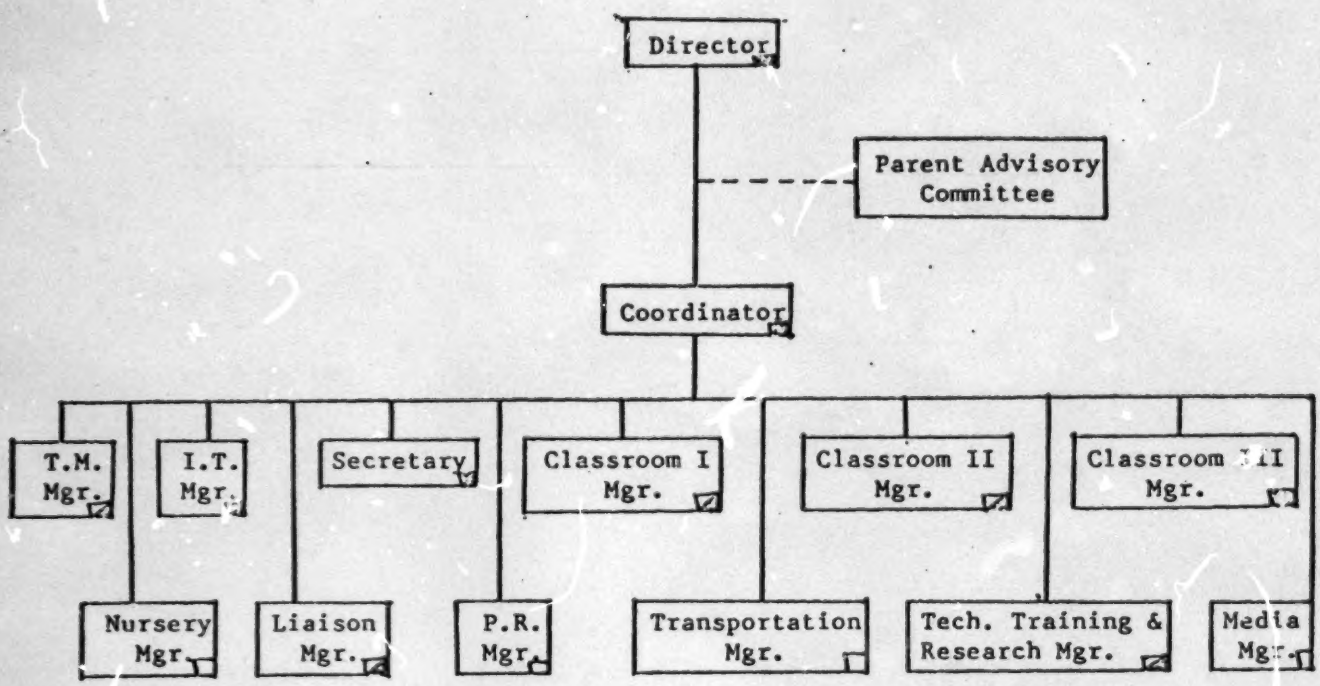
groups were identified in terms of marital problems vs. no such problems. Both groups were able to utilize clinic technique applications; however, the no-problem group quantitatively exceed their counterparts. The implication was that marital complications did not negate training effects, but were associated with less consistent use of training skills by these parents.

Conclusions. The conceptual model of EIP acknowledges and incorporates various concerns which have long persisted. These include reducing costs while simultaneously maintaining quality services, increasing the transfer of innovative technology from the literature to "real life" applications, training parent personpower, delivering immediate and intense services, and planning for generalization of intervention strategy effects across environments. Refinement in these areas must certainly occur, but EIP is now providing an innovative service approach with a true emphasis upon what maybe termed community participation or, more explicitly, active parent involvement. The fact that parents can be trained to systematically affect behavior change of their young children has been documented repeatedly.[9,10] Through parents, services can be extended to hundreds of thousands of children who otherwise might not receive them.

However, in order to construct and maintain such systems, multiple conceptual and real life considerations must command attention. Primary considerations include the consistent use of evaluation based upon output variables such as measured parent-child progress, and ultimate accountability to the consumers themselves. In view of the sparsity of childrens' programs across the nation, utilization of parents in the design, implementation, and evaluation of service delivery systems is long overdue.

EIP is made possible by a grant from the Office of Mental Retardation, Department of Public Welfare, and the funds are available through P.L. 89-313, an amendment to Title I of the Elementary and Secondary Education Act. In addition, county support is received for maintenance of program operation.

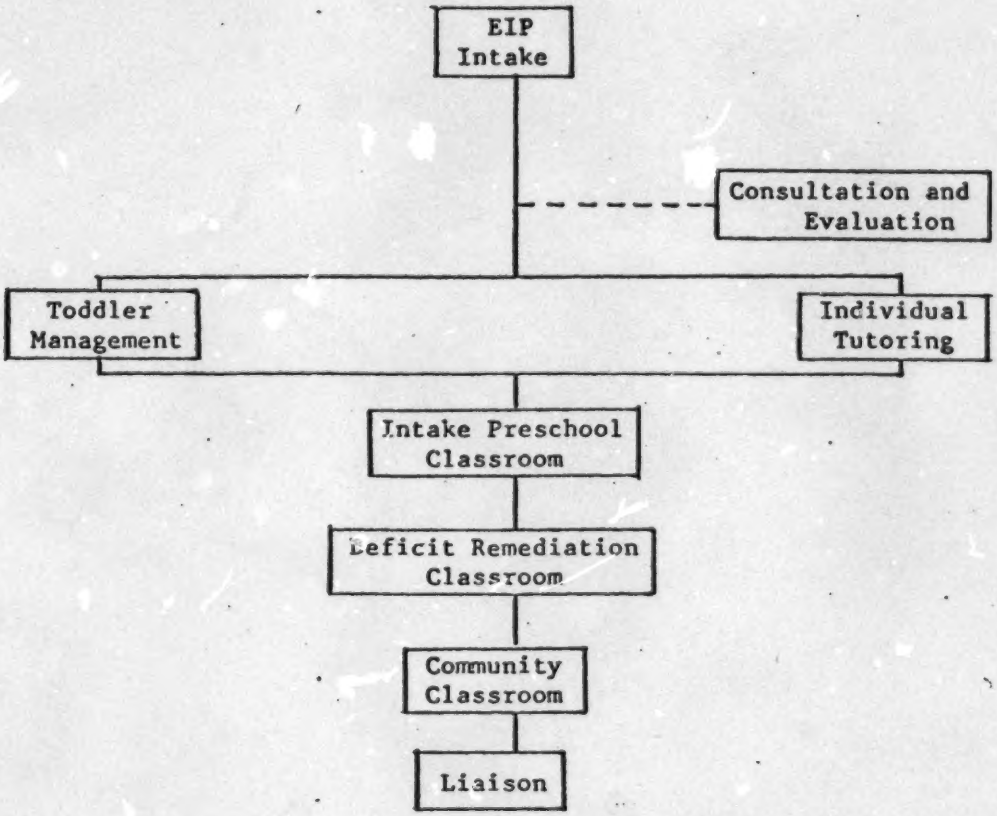
Table of Organization



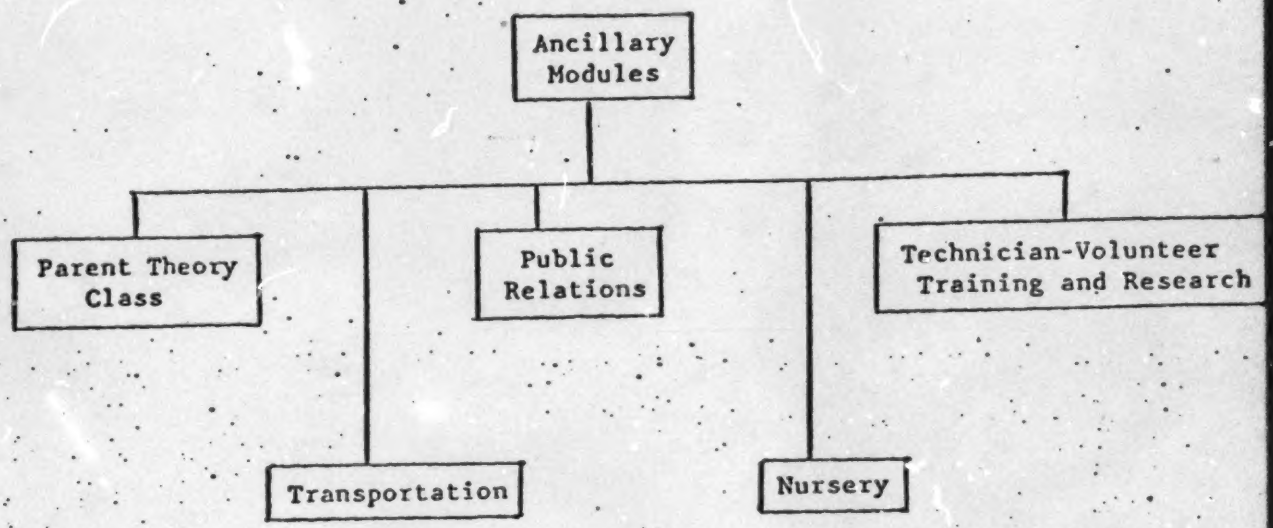
KEY:

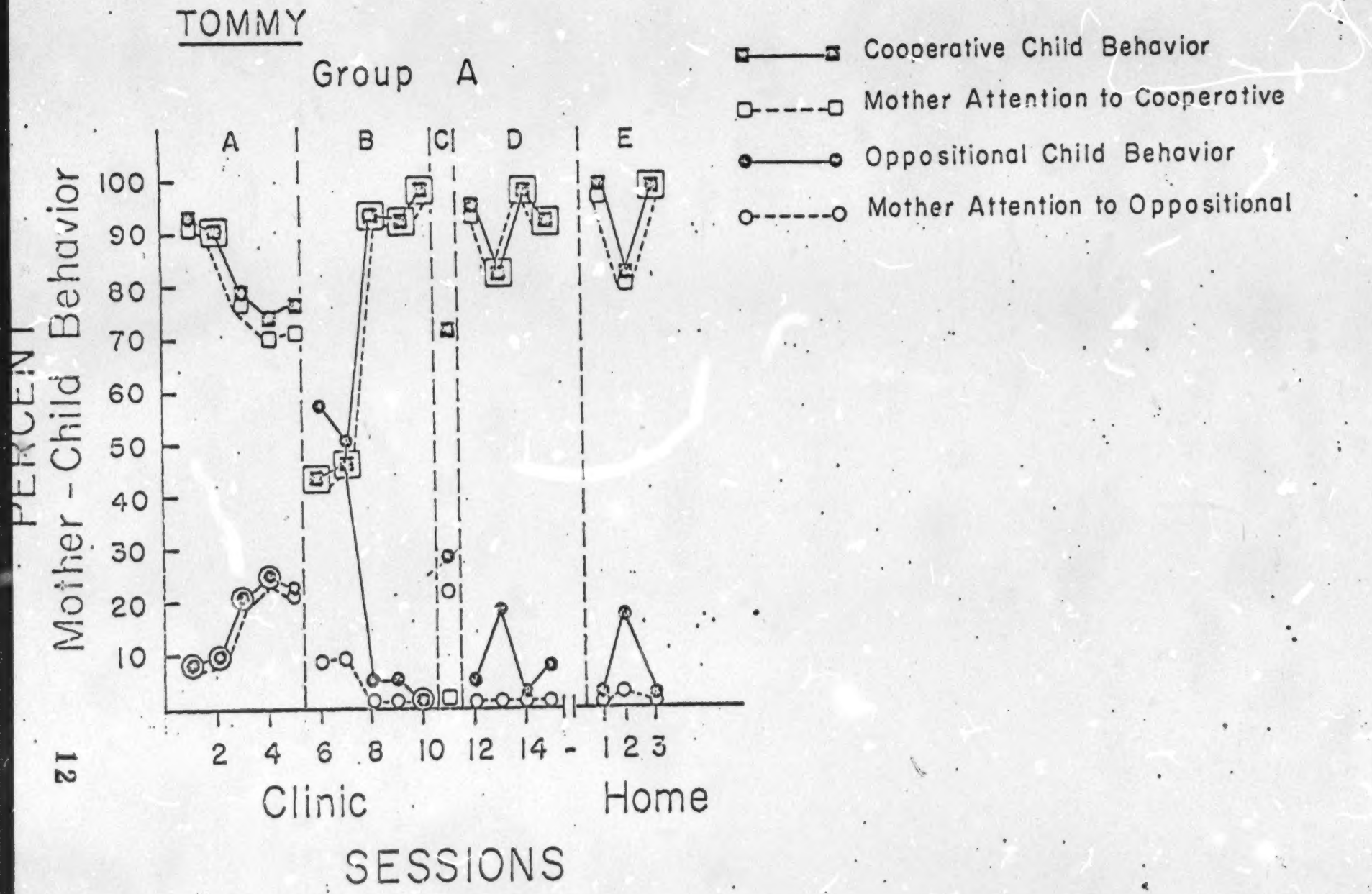
- ☐ - Full time paid professional staff
- ▨ - Half time paid trained nonprofessional staff
- ☐ - Volunteer trained nonprofessional staff

DIRECT SERVICE MODULE STRUCTURE



Ancillary Module Chart




TOMMY
Group A
Cooperative Child Behavior
Mother Attention to Cooperative
Oppositional Child Behavior
Mother Attention to Oppositional
A
B
C
D
E
PERCENT
Mother - Child Behavior
100
90
80
70
60
50
40
30
20
10
2 4 6 8 10 12 14 - 1 2 3
Clinic
Home
SESSIONS

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